Lyster Army Health Clinic Primary Care Manger Waiver Request

Date of Request: _____

Sponsor SSN: _____

Home
Address: _____

_____

_____

Contact Phone: _____

E-mail Address: _____

Please list all Family Members you are requesting a waiver for:

_____

_____

_____

_____

_____

Please briefly describe why you are requesting a waiver:

_____

_____

_____

_____

_____

_____

SIGNATURE: _____

*PLEASE ATTACH ANY SUPPORTING DOCUMENTS AND STATEMENT FROM THE CURRENT PCM

*Return completed forms to: ATTN Managed Care Division, 301 Andrews Ave., Ft. Rucker, AL 36362

*Fax completed forms to: (334)255-7224

*E-mail completed forms to: usarmy.rucker.medcom-lahc.list.bcac@mail.mil

Privacy Act Statement

This statement serves to inform you of the purpose for collecting personal information required by this system and how it will be used.

AUTHORITY: 10 U.S.C. Chapter 55, Medical and Dental Care; 32 CFR 199.17, TRICARE program; and E.O. 9397 (SSN), as amended.

PURPOSE: To collect information from Lyster Army Health Clinic beneficiaries in order to determine their eligibly for coverage under the TRICARE Program.

ROUTINE USES: Use and disclosure of your records outside of DoD may occur in accordance with 5 U.S.C. 552a(b) of the Privacy Act of 1974, as amended, which incorporates the DoD Blanket Routine Uses published at: http://dpclo.defense.gov/privacy/SORNs/blanket_routine_uses.ht ml.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Privacy Rule (45 CFR Parts 160 and 164), as implemented within DoD by DoD 6025.18-R. Permitted uses and discloses of PHI include, but are not limited to, treatment, payment, and healthcare operations.

DISCLOSURE: Voluntary; however, failure to provide information may result in the denial of enrollment.